Peer Request - Workers' Compensation

UMC Headquarters:
100 Elwood Davis Road, Suite 106 • North Syracuse, NY 13212
Phone • 877-862-4463 • Fax 315-453-2884

REFERRAL TYPE:

☐INDEPENDENT MEDICAL EXAM (IME) ☐IME RE-EXAM ☐FUNCTIONAL CAPACITY EVALUATION (FCE)
☐IMPAIRMENT RATING ☐PERMANENCY / SLU ☐RECORD REVIEW ☐RADIOLOGY REVIEW
☐SUPPLEMENTAL REPORT ☐OTHER:

SPECIAL INSTRUCTIONS: **DUE DATE:**

☐AUTO RESCHEDULE 1ST CANC. OR NO SHOW ☐CALL TO DISCUSS CHOICES ☐PLEASE PICK UP MEDICAL RECORDS
☐X-RAYS/DIAGNOSTICS AUTHORIZED ☐ CALL FOR TESTING AUTHORIZATION OTHER:

CLAIMANT INFORMATION:		REQUESTED BY:	
CLAIM NUMBER:		COMPANY NAME:	Date:
NAME:		NAME:	
ADDRESS:		TITLE:	
CITY/STATE:	ZIP:	ADDRESS:	
PHONE:		CITY/STATE:	ZIP:
SS#	DOB#	PHONE:	FAX:
EMPLOYER:		EMAIL ADDRESS:	

ATTORNEY INFORMATION:		INJURY INFORMATION:
ATTORNEY NAME:		DATE OF INJURY/LOSS:
ADDRESS:		ANCR/BODY PART(S):
CITY/STATE:	ZIP:	WCB NUMBER:
ATTORNEY PHONE:	FAX:	WAGE LOSS: ☐ YES ☐ NO

ATTENDING PHYSICIAN INFORMATION: **ADDITIONAL PHYSICIAN INFORMATION:**

TREATING PHYSICIAN NAME:	PHYSICIAN NAME:	
ADDRESS:	ADDRESS:	
TREATING PHYSICIAN PHONE:	PHONE:	FAX:

STOP

ROCKET DOCKET CASE: ☐ YES ☐ NO NEED REPORT BY:
HEARING LOCATION/CITY:

ANCR:

SPECIALTY NEEDED:

☐ORTHOPEDIST	☐NEUROLOGIST	☐ORAL SURGEON	☐PSYCHIATRIST (MD)	☐PMR
☐HAND SURGEON	☐NEUROSURGEON	☐DENTIST	☐PSYCHOLOGIST (PhD)	☐ENT
☐GENERAL SURGEON	☐PAIN MANAGEMENT	☐CHIROPRACTOR	☐OPHTHALMOLOGIST	☐INTERNIST
☐PLASTIC SURGEON	☐CARDIOLOGIST	☐OTHER:		

☐NAME OF REQUESTED IME PHYSICIAN:

ISSUES TO BE IDENTIFIED:

☐DIAGNOSIS
☐CAUSAL RELATIONSHIP TO INJURY
☐NEED FOR TREATMENT, TYPE & DURATION
☐NEED FOR SURGERY
☐MAXIMUM MEDICAL IMPROVEMENT
☐ABILITY TO RETURN TO WORK
☐TREATMENT REASONABLE NECESSARY & APPROPRIATE
☐PROGNOSIS
☐DEGREE OF DISABILITY (PER WCB GUIDELINES)
☐ESTIMATED DURATION OF DISABILITY
☐APPORTIONMENT OF DISABILITY
☐PERMANENCY RATING / SLU
☐M&S STATEMENT (2nd INJURY LAW)

COMMENTS: